Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: May 26, 2023	
Inspection Number: 2023-1070-0004	
Inspection Type: Critical Incident System	
Licensee: Carlingview Manor Operating Inc.	
Long Term Care Home and City: Carlingview Manor, Ottawa	
Lead Inspector Sarabjit Kaur (740864)	**Inspector Digital Signature** Sarabjit Kaur Digitally signed by Sarabjit Kaur Date: 2023.05.29 10:33:35 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 25- 28, 2023 and May 3, 2023
The inspection occurred offsite on the following date(s): May 4, 2023

The following intake(s) were inspected:
- Intake: #00015469 Resident to resident alleged sexual abuse.
- Intake: #00019063 - Resident to resident alleged physical abuse.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary
The plan of care dated on a specified date for resident #001 indicates that resident #001 has 1:1 in place for monitoring and the resident will not exhibit or be involved in any inappropriate close contact with any other resident.

On a specified date, there was sexually inappropriate behavior between resident #001 and #002. Resident #001 and #002 had a history of sexual behaviors in the past and this was the third incident. Resident #001 and #002 were in close proximity during the time of the incident. Resident #001 had a 1:1 at the time of the incident for inappropriate physical/unpredictable and sexual behaviors. In an interview with the DOC during the time of inspection, they confirmed that the 1:1 failed to fulfill their responsibility.
There was a moderate risk to the resident as resident #001 was allowed to have physical contact with resident #002.

Sources: CIS# 2420-000065-22 , progress notes and Interview with the DOC
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